Overcoming Stroke-Related Depression

How a nurse psychotherapist came to the rescue of one patient suffering the perplexities of a devastating cerebrovascular accident.

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Depression frequently accompanies cerebrovascular accidents (CVA) in the elderly. Following a CVA (or stroke), individuals often have difficulty in making life adjustments. Psychotherapy may be instrumental in helping elderly persons to recover from a stroke. Nurse psychotherapists (NPT) can assist these clients and their families to cope with the effects of this illness through the implementation of individualized nursing therapies. This article describes how one nurse psychotherapist helped an elderly client overcome stroke-related depression by implementing an individualized plan of care.

Stroke and its Psychosocial Implications

Stroke hits 1.2 Americans per minute, often without warning. While these statistics suggest that CVAs remain a major health problem of Americans, the death rate from stroke declined 46% between 1968 and 1981 because of lifestyle changes and improvements in treatment.1 Strokes affect six elderly persons for every one younger person, and kill an estimated 275,000 persons annually in the United States, leaving another 300,000 with various disabilities.2 These disabilities and functional limitations may be transient or permanent, leaving the victim with either physical or psychological impairments.

The extent of any mental dysfunction is dependent upon numerous factors, including the site of the CVA; the affected individual’s previous coping patterns; the possession of adequate economic resources; the presence of a strong social support system; and the availability and appropriateness of medical interventions. Mental functioning limitations may include the following: limited attention span, difficulties in comprehension, forgetfulness, and lack of motivation. Problems with communication may include difficulties in speaking (dysarthria); defective speech or loss of speech (dysphasia or aphasia); and inability to perform a previously learned action (apraxia).3

These losses, along with impairments in physical functioning, can result in temporary or long-term changes in the patient’s mood or behavior.4 These psychological changes, possibly linked to the site of the CVA, include dysphoria, depression, sadness, anxiety, mania, paranoia, euphoria, and anger.5

While many factors affect an elderly person’s reaction to a stroke, key factors are believed to include the general meaning of the disease to the patient, perception of any loss of function and its consequences; reactions of the patient’s friends and relatives; responses of the social network; effects on physical appearance; the degree of loss of status and finances; and the interaction between associated ailments and treatments.

Among the most common and disabling responses to stroke are loss of control, specific fears, loss of dignity, separation and isolation, and role reversal. Family reaction may include denial, acting without adequate information, and family discord and dissolution. Nurses who practice in hospital settings, community clinics, or extended care facilities are in a position to help these clients on a daily basis to meet biopsychosocial needs, as well as provide support to the families.
Families of stroke victims confront perplexing questions about how best to help their loved one. Several recent publications may assist patients and their families in adjusting to changes precipitated by the stroke. After a stroke patient has recovered to the point that he or she no longer needs hospitalization, families frequently help to determine future services and living arrangements. If the stroke victim has suffered serious motor-perceptual losses, nursing home placement may seem the only acceptable alternative. Nursing home placement for stroke victims is a relatively recent phenomenon generated, in part, by the entry of women into the work force in increasing numbers, changes in family lifestyle, and the disintegration of nuclear and extended families.

In spite of changes in family structures and lifestyles, families still assume a sense of responsibility for the welfare of loved ones affected by a catastrophic illness. Decisions concerning living arrangements following a stroke are often difficult for the client and family members. If possible, the stroke victim should always be consulted regarding his wishes, but family members must also consider that impaired judgment may accompany a stroke. Moreover, communication difficulties sometimes leave the stroke victim unable to communicate his or her wishes. The stroke victim may also be struggling with significant emotional trauma as a consequence of perceived or actual losses; those of self-esteem, self-identity, mobility, speech, sexual functioning, memory and judgment, income, family, and friends.

In view of these factors, family members often experience considerable difficulty in reaching a decision about living arrangements for the stroke victim. A final decision is often complicated by the family's own personal circumstances and lifestyle. For example, the cost of health care maintenance of a stroke victim is often a consideration which the family must weigh. Sometimes, a final decision regarding living arrangements is not entirely satisfactory for either the patient or his family. Families often experience conflict and a sense of guilt or anger during and following this decision-making process.

**Case Study of a Depressed, Elderly Stroke Victim**

Mrs M. was a 66-year-old female who had suffered a stroke nine years before her contact with the NPT, resulting in left hemiplegia. Her family requested the services of an NPT after they recognized that depression was interfering with her daily functioning and rehabilitation. At the time of the request, E.M. was living in a nursing home which gave permission for the consultation.

**Health History**—E.M. had suffered a carotid aneurysm at 58 years of age. Following her husband's death in 1978, she moved to a private home near that of her daughter where day workers assisted in her daily care. However, this arrangement proved to be unsatisfactory because of the "untrustworthiness" of the caregivers. The daughter then arranged for E.M. to move to a nursing home where she could receive physical therapy, activity therapy, and nutritional supplements. After two years, E.M. moved to another nursing home. This move was prompted by two factors: dislike for the variety and quality of the food served at mealtimes, and a need to be the sole decision-maker in selecting a nursing home. She had lived in the second nursing home for 18 months when she was referred to the NPT.

**Biopsychosocial Assessment**—E.M.'s mental status was evaluated at the first session. She was dressed in a coordinated pantsuit with her hair combed and makeup applied. She sat slumped in a wheelchair with her affected arm held loosely in place by a sling. Her face looked tired and she gave the appearance of fragility. Her sad expression underscored her weeping as she talked of her past life and current frustrations. She reported no difficulties in sleeping. In fact, she preferred to stay in bed whenever possible. While she reported no specific physical problems, she did need assistance with activities of daily living because of her hemiplegia.

Both her verbal and nonverbal communication conveyed a depressed affect; she was oriented in all spheres; remote and recent memory were intact as was her judgment; her thoughts progressed in a logical and orderly flow; and she did not demonstrate any imagery perceptual difficulty. The richness of her vocabulary suggested an educational background. She had earned a teacher's certificate upon completion of two years of university study.

E.M. had experienced numerous losses. Her first daughter, the mother of eight children, had died eight years earlier at age 36 from cancer. A second daughter had died of pneumonia 31 years earlier (at two years of age). E.M. herself had had tuberculosis of the fallopian tubes at age 38, requiring a hysterectomy. Her husband had succumbed to pneumonia secondary to carcinoma of the throat. E.M., who continuously focused upon her losses during the first session, had never accepted limitations imposed by her stroke. She dwelled, for example, upon how she had been forced by her circumstances to relinquish the home and friends she had shared with her husband.

On a more positive note, E.M. reported that she was fairly satisfied with the nursing home in which she lived. She reported that she was chairperson of the residents' government organization, although she did not always attend meetings or planned activities. She identified at least two persons with whom she could talk at the home, although "they don't really listen." An extensive primary support system included her daughter and 14 grandchildren. However, she saw eight of these grandchildren, who lived 85 miles from her, only occasionally. Many family members maintained contact with her through visits, letters, and telephone calls.

Data from her chart suggested other possible health problems for E.M.: She weighed 72 pounds, approximately 13 to 18 pounds less than her ideal body weight; and she was described as having "borderline" hypertension. She was also receiving multiple prescription drugs at the time of the initial assessment.

Her daughter determined that it was important for E.M. to have coordinated
care between her physician and the nurse psychotherapist. After E.M., her
daughter, and the NPT discussed her medical regimen and the kind of medi-
cal care she desired, E.M. decided to seek a new physician. Following
this decision, her new physician completed a thorough physical examination
of E.M. and openly discussed a medical treatment plan with her and the NPT.
This plan included the discontinuation of many of the medications E.M. had
been taking and the prescription of a low-dose tricyclic antidepressant,
amitriptyline hydrochloride. This drug was prescribed to combat her pervasive
sadness, feelings of hopelessness and helplessness, psychomotor retardation,
and sleep disturbances.

After the initial mental status assessment was completed, E.M. agreed to
take a battery of psychological tests. A qualified psychologist administered the
Bender visual-motor gestalt test to assess the extent of any damage to the
parietal lobes. Results suggested an element of spatial distortion, but this did
not preclude her use of a pencil for further testing. She then took the
Wechsler Adult Intelligence Test (WAIS) which contains a variety of
assembly and completion tests requiring varying levels of perception, analysis,
and manipulation of visual-spatial reasoning. Although some perceptual
difficulty was identified, her cognitive spatial perception was within
acceptable limits. The WAIS intelligence test indicated that her performance
ranked at the high end of normal. Initially she had feared taking the tests,
thinking that she was “stupid” as a result of her stroke. Test results dis-
pelled these fears and motivated her toward higher levels of functioning and
rehabilitation goals.

Nursing Interventions

During the initial session, E.M. identified two goals: to feel better about
herself and to accept the limitations imposed by her stroke. The NPT
advised E.M. that depression often accompanies stroke and that she had
some symptoms of depression which were possibly interfering with her cop-
ing abilities. She agreed to meet with the NPT twice per week for one hour
sessions. During these sessions, a cognitive therapy approach was imple-
menced to enable E.M. to identify positive thoughts, feelings, and
behaviors. Following these interventions, attention was focused upon helping
her to determine negative factors that reinforced her depressed mood.
Early sessions were characterized by an exploratory therapy style which allowed
her to ventilate her feelings, to redirect her anger, and to resolve her feelings of
guilt. In later sessions the NPT used role-playing techniques to help her
develop assertive behaviors which she had suppressed. E.M. was also encour-
aged to read Burn’s Feeling Good which emphasizes a cognitive approach to
resolving depression.

The early sessions were used to gather a more complete history of E.M.
and to develop rapport and trust. She identified one of her major problems as
difficulty in socializing with other residents, since only two or three did not
have problems related to organic brain disease. Her roommate, for example,
called out incoherently throughout the night, preventing E.M. from sleeping
well. These early sessions were complicated when, after six weeks of therapy,
one of E.M.’s grandparents committed suicide. She became more depressed
and reduced her food intake to the extent that she lost ten pounds. She left
her bed only briefly to eat small amounts, after which she would return
to her room to cry. Her mental alertness became progressively clouded, leading
the nursing home staff to request hospitalization for her. However, because she
associated hospitalization with death, an alternative approach was considered.

With the cooperation of E.M., her family, her physician, the nursing
home staff, an intensive individualized plan of care was designed and
instituted. The purpose of this plan of care, which involved a one-to-one treat-
ment program 12 hours per day, was to provide E.M. with adequate support
and stimulation to stabilize her physical condition and to help her become less
depressed.

Two private duty nurses were hired to work two six-hour shifts to implement
the highly structured program. These nurses were responsible for carrying
out the program and charting E.M.’s responses. The nurses were to be kind
and supportive, yet firm, while executing the program. Because of her weight
loss, E.M.’s food intake was to receive special attention, including spoon feed-
ing to compensate for her lack of motivation to eat. Mealtime often
required two hours. In addition, small high protein supplements were
provided between meals.

A number of activities were planned for stimulation. For example, a record
player was obtained so that she could listen to her favorite music. The nurses
took her to different areas of the home as a change of setting for varied
activities. Initially her favorite poems were read to her. Later, as she began to
improve, she read poetry to the nurses. She was encouraged to participate in
arts and crafts activities on a daily basis, displaying the results of her crea-
tive efforts in her room. Other diversional activities included table games
and games requiring a short attention span. She was also encouraged to write
to her family and friends during this period. To cope with the tension and
anxiety she felt, she listened daily to a progressive relaxation tape which was
correlated with appropriate imagery. Nap times, as well as free time, were
provided each day.

After seven weeks in this program, E.M. developed more interest in self-
care. She began to feed herself and to participate more actively in the div-
erisonal activities. As E.M. began to feel better, she became more verbal, and she
expressed her feelings more fully with the nurse psychotherapist who met with
her three or four times per week during this period. E.M.’s anger during this
time occasionally manifested itself in the form of resistance. At times she
refused to eat or to participate fully in the planned activities. However, after
three months, she had improved to the point that her supervised program time
could be gradually reduced from 12 hours to four hours daily.

As E.M.’s depression lifted, she wanted to participate in community
events. Her diverse interests and appreciation of the arts stimulated her to
attend plays, symphony concerts, and musical performances. She was also
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accompanied by staff and family members on shopping expeditions, to dinner, and to a wide variety of other attractions. Slowly she became reengaged in the regular activities of the nursing home, including ward meetings. She began to write poetry for the newsletter printed at the nursing home.

In spite of E.M.'s improved functioning and a slow but steady increase in her weight, she continued to view herself as living in a hopeless situation. Because of this sense of hopelessness with respect to her living situation, alternatives to the nursing home were explored. It was learned that her health insurance would provide for 80% reimbursement for in-home care by either a registered nurse or licensed practical nurse. Her physician, who supported E.M.'s efforts to become more independent, wrote a letter outlining her health care needs. Eventually most of her nursing care costs were paid by the insurance company, including the costs of nurse psychotherapy.

Apartment-type facilities for senior citizens existed in E.M.'s community, several of which she visited. She ultimately chose an apartment which included a bedroom, living room, dining room, and galley kitchen. In the apartment complex she chose, senior citizens with disabilities are required to have a 24 hour companion. After consulting with E.M., the NPT hired two full-time, live-in companions, each working 12 hour shifts.

E.M. eagerly anticipated having her own home again. She made a list of housekeeping items and discussed with her daughter items from her former home which were still usable. During the next eight weeks, E.M. made numerous shopping trips to decorate and furnish her new home. Concurrently she began to do volunteer work for an organization, an experience that helped her to reestablish a sense of self-worth and productivity. At first, E.M. stamped brochures which were brought to her. As her health improved, she went to the office of the organization, where she was provided with a desk which added to her sense of purpose and belonging.

Since moving to her new home, E.M. has established a daily schedule which includes two weekly visits to her volunteer job, bingo one evening per week, and Bible study once per week, as well as excursions to cultural events. She walks with the assistance of her companions on a daily basis. E.M. plans her meals on a weekly basis and goes to the market if the weather permits. For the most part, the companions prepare meals. Although her appetite has continued to fluctuate, her weight has remained stable.

Thanksgiving in E.M.'s new home was very special for her. For this holiday most of her grandchildren came "home" where she had reserved the recreation room for this occasion. She assisted her daughter as much as possible with food preparation and expressed much happiness about being able to entertain her family.

The NPT continues to see E.M. once per week in her home. E.M. uses this
time to talk about her frustrations and to develop coping skills. The nurse assesses her physical condition and arranges for her to see her physician every six to eight weeks. The NPT also uses some of this time to collaborate with E.M.'s companions and teach them how to help her. E.M. also receives support from her participation in monthly meetings of a stroke club in her community.

As a result of the interventions cited above, E.M.'s sense of self-esteem has improved and her depressive mood swings have become less frequent. Moreover, she has a home she can call her own—and people she can relate to, thus enabling her to offset a part of her losses. Her daughter feels relieved to know that a professional nurse is coordinating her mother's care and is readily accessible should any questions or problems arise.

While the extensive plan of care described here may not be feasible for many stroke victims because of economic considerations and other factors, the changes in E.M. illustrate the value of consultation by a nurse psychotherapist for an elderly client with stroke-related depression. Many of the approaches described can be adapted in care plans being developed for depressed elderly stroke victims. E.M.'s improvement suggests that individualized approaches to the treatment of depression accompanying stroke in the elderly can be effective in helping clients to achieve a greater well-being and a fuller, more productive life.

References

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